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PSYCHOSOCIAL ISSUES WITH POST- TRAUMATIC STRESS DISORDER AND TREATMENT FOR THE VETERAN POPULATION

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PSYCHOSOCIAL ISSUES WITH POST-TRAUMATIC STRESS DISORDER AND
TREATMENT FOR THE VETERAN POPULATION

by

Joleen Skortz

B.S., Southern Illinois University, 2009

A Research Paper

Submitted in Partial Fulfillment of the Requirements for

The Master of Science Degree

The Rehabilitation Institute

In the Graduate School

Southern Illinois University Carbondale

August 2012

RESEARCH APPROVAL

PSYCHOSOCIAL ISSUES WITH POST-TRAUMATIC STRESS DISORDER AND
TREATMENT FOR THE VETERAN POPULATION

by

Joleen Skortz

A Research Submitted in Partial
Fulfillment of the Requirements
for the Degree of
Master of Science
in the field of Rehabilitation Counseling

Approved by:

Dr. James Bordieri, Ph. D

Graduate School
Southern Illinois University Carbondale
June 28, 2012

AN ABSTRACT OF THE RESEARCH PAPER OF

JOLEEN SKORTZ, for the Master of Science degree in Rehabilitation Counseling, presented on June 28, 2012 at Southern Illinois University at Carbondale.

TITLE: Psychosocial Issues with Post-traumatic Stress Disorder and Treatment for the Veteran Population

MAJOR PROFESSOR: Dr. James E. Bordieri, Ph.D

Post-Traumatic Stress Disorder is an anxiety disorder that occurs after a traumatic event in which the threat of serious injury or death was experienced or witnessed. Symptoms of PTSD are wide ranging often include psychiatric co-morbidity that can significantly affect many aspects of an individual's life. Evidence suggests that PTSD among veterans is increasing, with higher numbers of veterans needing to seek more services. However, evidence suggests that many veterans who have begun to receive treatment for PTSD do not always finish the recommended course of treatment. The Veterans Administration is working to expand mental health services while also discovering ways to overcome barriers for veterans seeking mental health treatment, while also increasing the retention rate among veterans who are receiving services. PTSD has been shown to increase thoughts of suicide among veterans. There are effective treatments for veterans with PTSD which include individual, family, and group therapy. Medication is also utilized to help manage symptoms. The roles of rehabilitation counselors have been acknowledged and expanded to effectively provide the necessary treatment to best serve veterans with PTSD.

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CHAPTER 1

INTRODUCTION TO THE PROBLEM

Overview of the Problem

This problem investigates how symptoms of Post-Traumatic Stress Disorder (PTSD) encompass many aspects of a veteran's life ranging from acute psychological stress and psychiatric co-morbidity, significant social maladjustment, and poor quality of life (Magruder, Fruesh, Knapp, Johnson, Vaughn III, Coleman, Powel, & Herbert, 2004). Epidemiological estimates of PTSD put the "lifetime prevalence at 8-14% in the general population, with higher rates of both current (up to 15%) and lifetime (up to 13%) prevalence for veterans exposed to war zone trauma" (Magruder, et al., 2004, p. 293).

Recent evidence suggest that, compared to most other psychiatric disorders, PTSD in the general population is associated with higher rates of service use and higher medical and societal cost (Magruder, et al., 2004). Symptoms of PTSD such as the cluster of avoidance symptoms which includes; a loss of interest in important and once positive activities and feeling as though one's life has been cut short. The perception such avoidance features such as sense of a shorter future, in which an individual may believe that normal life activities are not available to them dramatically affects quality of life.

Research that has examined the effect of PTSD on intimate relationships reveals severe and pervasive negative effects on marital adjustment, general family functioning, and the mental health of partners and children. These negative effects result in such problems as compromised parenting, family violence, divorce, aggression, and caregiver burden (Calhoun, Beckham &

Bosworth, 2002). Since PTSD affects the entire family, treatment is necessary for the family members also.

The physiological changes associated with acute stress and PTSD include increases in sympathetic, and decreases in parasympathetic, tone and release of ACTH, cortisol, and catecholamines from the pituitary, adrenal cortex, and adrenal medulla, respectively (Yehuda & LeDoux, 2007). These and related physiological adjustments of autonomic nervous system (ANS) and organs (i.e., changes in the heart rate, blood pressure, respiration, skin conductance) represent adaptive responses, as they help the body accommodate to an immediate demand. "A critical feature of the stress response is the auto-regulation initiated by cortisol negative-feed-back inhibition, that restores stress-related reactions to baseline after the termination of the acute stressor" (Yehuda & LeDoux, 2007, p. 19). These physiological changes can lead to other mental and physical health disorders.

There are many common co-occurring disorders with PTSD, such as substance abuse or mental health issues (Souza & Spates, 2008). Up to half of adults with both drinking problems and PTSD also have one or more of the following serious symptoms: anxiety type features such as panic attacks, extreme fears or worries, or compulsions; mood problems such as depression, sleep disturbance, attention problems or behaving in ways that harm others; addiction to or abuse of street or prescription drugs; long-term physical illness such as diabetes, heart disease, or liver disease; or ongoing physical pain (Souza & Spates, 2008). Co-occurring disorders lead to negative coping, which often accompanies PTSD. Common methods of negative coping involve alcohol and substance abuse.

Co-occurring disorders present social challenges. Some social challenges include the stigma of seeking mental health (and/or substance abuse) treatment; unfortunately, the societal,

as well as the individual's, perception of possible stigma has kept many veterans from seeking much-needed therapy. Having a co-morbid disorder in addition to PTSD further increases veteran's risk of suicidal tendencies.

Purpose of Paper

The purpose of this paper is to educate veterans with PTSD and their families about the disorder so they can gain an understanding of it, its symptoms, possible co-occurring disorders, and the psychosocial effects that are common with PTSD. Moreover, this paper will explore the education, resources and counseling that are available, not only for treating the veteran with PTSD, but also the veteran's family. Furthermore, it will assist in gaining a further understanding and increased recognition of the psychosocial effects of PTSD on a veteran's life. How these psychosocial issues affect every day functioning can have as significant impact on the quality of life of the family as it does on that of the veteran. This paper will work to acknowledge the real and perceived stigma of receiving mental health treatment, the effects of this stigma, and what is being done to acknowledge this issue and combat stigma. This paper will examine the most effective ways to treat PTSD and co-occurring disorders, and also recognize counseling strategies and treatment protocol that are most effective in treating PTSD and co-occurring disorders. This paper will illustrate an increased demand for PTSD treatment services for Iraq and Afghanistan veterans, and discuss the challenges in providing these necessary services. Finally, this paper will address the need for further research exploring PTSD among veterans and their families.

Definition of Terms

The Diagnostic Statistical Manual IV-Text Revisions criteria for PTSD begins with a stressor;

the person has been exposed to a traumatic event in which both of the following have been present: 1: The person has experienced or witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others. 2: The person's response involved intense fear, helplessness, or horror. Note in children, it may be expressed instead by disorganized or agitated behavior.

Intrusive recollection must occur to meet PTSD criteria. The traumatic event is persistently re-experienced in at least **one** of the following ways: 1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed. 2. Recurrent distressing dreams of the event. Note in children, there may be frightening dreams without recognizable content. 3. Acting or feeling as if the traumatic event were recurring (includes sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in children, trauma-specific reenactment may occur. 4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. 5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Avoidant/numbing must occur to meet PTSD criteria this is the Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least **three** of the following: 1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma. 2. Efforts to avoid activities, places, or people that arouse recollections of the trauma. 3. Inability to recall an important aspect of the trauma. 4. Marked diminished interest or participation in significant activities. 5. Feeling of detachment or estrangement from others. 6. Restricted range of affect (e.g., unable to have loving feelings). 7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

Hyper-arousal must be present to meet PTSD criteria. Persistent symptoms of increasing arousal (not present before the trauma, (indicated by at least **two** of the following: 1. Difficulty falling or staying asleep. 2. Irritability or outburst of anger 3. Difficulty concentrating 4. Hyper-vigilance 5. Exaggerated startle response.

Duration must occur to meet criteria for PTSD. Duration of the disturbance (symptoms in B, C, and D) is more than one month. Functional significance this must occur to meet PTSD criteria.

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. *Specify If:* Acute: if duration of symptoms is less than three months Chronic: if duration of symptoms is three months or more *Specify If:* With or without delay onset: Onset of symptoms at least six months after stressor. (DSM IV- TR, 2000 pp. 467-468)

CHAPTER 2

REVIEW OF LITERATURE

Introduction to the Etiology and Medical Condition of PTSD

According to Kean, Marshall, and Taft (2006), PTSD results from exposure to a traumatic event that poses actual or threatened death or injury and produces intense fear, helplessness, or horror. In such an event, there are physiological changes that occur in the brain. Additionally, according to Celada, Puig, Martin-Ruiz, Casanovas, and Artigas (2002), the prefrontal cortex participates in a large number of cognitive and associative functions leading to the planning and executing of complex tasks. Mental illness has been associated with an abnormal function of prefrontal areas (Celada, et al., 2002). The authors go on to say, "compared to healthy individuals, patients with PTSD show a reduced regional cerebral blood flow in various prefrontal areas" (Celada, et al., 2002, p. 409). The physiological changes in the brain affect its chemical structure, which produces symptoms of PTSD.

As stated in the overview, according to Yehuda and LeDoux (2007), physiological changes associated with acute stress and PTSD include increases in sympathetic, and decreases in parasympathetic, tone and release of ACTH, cortisol, and catecholamines from the pituitary, adrenal cortex, and adrenal medulla. (Yehuda & LeDoux, 2007). They have noted that "These and related physiological adjustments of autonomic nervous system (ANS) end organs (i.e., changes in the heart rate, blood pressure, respiration, skin conductance) represent adaptive responses, as they help the body accommodate to an immediate demand" (Yehuda & LeDoux, 2007, p. 19). The authors state that a critical feature of the stress response is the auto-regulation initiated by cortisol negative feedback inhibition that restores stress-related reactions to baseline after the

termination of the acute stressor (Yehuda & LeDoux, 2007). PTSD symptoms are a result of these physiological changes.

PTSD symptoms usually start soon after the traumatic event, but they may not happen until months or years later. PTSD symptoms may also come and go. If the symptoms last longer than 4 weeks, cause great distress, or interfere with work or home, one may have PTSD. Yehuda and LeDoux (2007) discuss three distinct but co-occurring, symptom clusters, which are "*Re-experiencing symptoms*: [these] describe spontaneous, often insuppressible intrusions of the traumatic memory in the form of images or nightmares that are accompanied by intense physiological distress. *Avoidance symptoms* involve restricting thoughts and distracting oneself from reminders of the event, as well as more generalized emotional and social withdrawal. *Hyper-arousal symptoms* reflect more overt physiological manifestations, such as insomnia, irritability, impaired concentration, hyper-vigilance, and increased startle responses" (Yehuda & LeDoux, 2007 p. 20).

It is important to have a review of the etiology and the resulting physiological changes that occur in order to better understand the psychological effects of PTSD and the common co-occurring disorders.

Psychological and Co-occurring Disorders

Evidence from Souza and Spates (2008), suggests that PTSD is often co-morbid with other Axis I and Axis II disorders. Up to half of adults with both drinking problems and PTSD also have one or more of the following serious symptoms: "Panic attacks, extreme fears or worries, or compulsions, mood problems such as depression, sleep disturbance, attention problems or behaving in ways that harm others, addiction to or abuse of street or

prescription drugs, alcohol use and abuse, and long-term physical illness such as diabetes, heart disease, liver disease, and ongoing physical pain" (Souza & Spates, 2008 p. 12).

Effective Treatment(s) for PTSD

The Veterans Administration offers several different effective treatments for PTSD as well as co-morbid and co-occurring disorders. According to Monson, Schnurr, Resick, Friedman, Young-Xu, and Stephens (2006) The V.A. recognizes and provides two forms of cognitive behavioral therapy to veterans with PTSD: Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) therapy (Monson, et al., 2006).

According to the Monson, et al., (2006) Cognitive Processing Therapy (CPT) has been shown to be one of the most effective treatments for veterans PTSD (2006). For this reason, the VA's Office of Mental Health Services has begun a national therapist training program. VA therapists throughout the country will be trained in how to use CPT treatment. These therapists will also consult with CPT experts to learn how to best provide this therapy. Then they will be asked to use CPT in their routine clinical care. According to Monson, et al., (2006) Cognitive Processing Therapy (CPT) is a type of the evidence-based practice therapy known as cognitive behavioral therapy (CBT), which is used by clinicians to help individuals recover from PTSD (2006). CPT typically consists of 12 sessions and has been shown to be effective in treating PTSD across a variety of populations, including combat veterans (Monson, et al., 2006). During the course of CPT, the primary focus is to help patients gain an understanding of, and modify the meaning attributed to, their traumatic event (Monson et al., 2006). An important goal of CPT is to decrease the pattern of avoiding the trauma memory so that beliefs and meanings can be further evaluated and understood within the original context (Monson, et al., 2006). Individuals are assisted in understanding their conceptualization of why the event occurred and

the impact it had on their beliefs about themselves, others, and the world. In this phase of treatment, a large focus is on the identification of automatic thoughts and increasing awareness of the relationship between a person's thoughts and feelings (Monson, et al., 2006). A patient is taught to identify difficulties in progression which are problematic beliefs that interfere with recovery from traumatic experiences (Monson, et al., 2006). The next phase of CPT involves formal processing of the trauma. Patients are asked to write a detailed account of their worst traumatic experience, which they read to the therapist in session (Monson, et al., 2006). By writing the account of their worst traumatic experience, veterans break the pattern of avoidance and increase the process of dissipating the strong emotions that they have to proceed in the course of recovery (Monson, et al., 2006). Emotional processing continues throughout the course of CPT as veterans discuss their traumatic experiences in efforts to modify their maladaptive beliefs. Clinicians work with the veteran to help them challenge their thinking about their traumatic event and become increasingly able to decrease self-blame, guilt, and increasing acceptance (Monson, et al., 2006). The final phase of treatment focuses on teaching the veteran the cognitive skills necessary to identify, evaluate, and modify their beliefs as necessary regarding any and all traumatic events they have experienced (Monson, et al., 2006). Now patients can work to identify and work to better to understand and challenge habitual and unrealistic conclusions about their traumatic experience. The skills learned help the veteran to be able to engage in adaptive coping outside of therapy, and to continue to apply what is learned when therapy sessions are over. Twelve 50-minute sessions typically once or twice weekly, patients complete out-of-session practice assignments (Monson, et al., 2006).

Also utilized is Prolonged Exposure Therapy (PE), which is a form of behavior therapy and cognitive behavioral therapy designed to treat PTSD. PE therapy is characterized by re-experiencing the traumatic event by remembering and engaging with it, rather than avoiding reminders of the trauma (Eftekhar, Steins, & Zoliner, 2006). According to Eftekhar, Steins, and Zoliner (2006) PE is a theoretically-based and highly effective treatment that is commonly utilized for combat veterans with PTSD and related depression, anxiety and anger (2006). Based on behavioral principles, it is empirically validated, with more than 20 years of research supporting its use (Eftekhar, et al., 2006). PE is specifically designed to help veterans psychologically process traumatic events and reduce trauma-induced psychological disturbances (Eftekhar, et al., 2006). Prolonged exposure produces clinically significant improvement in about 80% of patients with chronic PTSD (Eftekhar, et al., 2006). PE has been beneficial for those with co-occurring PTSD when combined with substance abuse treatment (Eftekhar, et al., 2006). PE works to address the traumatic memories and triggers that are reminders of the trauma. The core components of exposure programs for PTSD are: “1. imaginal exposure, revisiting the traumatic memory, repeated recounting it aloud, and processing the revisiting experience; and 2. *in vivo* exposure, the repeated confrontation with situations and objects that cause distress but are not inherently dangerous” (Eftekhar, et al., p.70, 2006). The goal of this treatment is to promote processing of the trauma memory and to reduce distress and avoidance evoked by the trauma reminders (Eftekhar, et al., 2006). Additionally, veterans with emotional numbing and depression are encouraged to engage in enjoyable activities that the individual has discontinued due to loss of interest (Eftekhar, et al., 2006). The imaginal exposure typically occurs during the therapy session and consists of retelling the trauma to the therapist. For the “*in vivo* exposure, the clinician works with the client to experience a fear and avoidance hierarchy and typically assigns

exposure to these list items as homework progressively” (Eftekhari, et al., p. 70, 2006). Both components work by facilitating emotional processing so that the problematic traumatic memories and avoidances desensitize (Eftekhari, et al., 2006). The distress of PTSD may be highest when dealing with memories, thoughts, feelings, and situations that are related to the trauma. Exposure therapy is a type of therapy that helps a veteran decrease distress about combat trauma (Eftekhari, et al., 2006). This therapy works by helping the veteran approach trauma-related thoughts, feelings, and situations he or she has been avoiding due to the distress they cause (Eftekhari, et al., 2006). Repeated exposure to these thoughts, feelings, and situations helps reduce the power they have to cause distress. Prolonged Exposure (PE) is one exposure therapy that works for many people who have experienced trauma (Eftekhari, et al., 2006). It has four main parts: “education, breathing, real world practice, and talking through the trauma” (Eftekhari, et al., p. 70, 2006).

Medications have also been shown to be effective. A type of drug known as a selective serotonin reuptake inhibitor (SSRI), which is also used for depression, is effective for PTSD (Hamblin, 2010). SSRIs are a type of anti-depressant medication which can help alleviate symptoms of depression and anxiety and include; citalopram (Celexa), fluoxetine (such as Prozac), and sertraline (Zoloft) (Hamblin, 2010).

According to Hamblin (2010) group therapy is another type of counseling; many veterans want to talk about their trauma with others who have had similar experiences. In group therapy, a veteran will talk with a group of veterans who also have been through trauma and who have PTSD (Hamblin, 2010). Sharing one’s story with others may help a person feel more comfortable talking about their trauma. This can help a veteran cope with their symptoms, memories, and other aspects of life. Group therapy helps a veteran build relationships with others

who understand what he or she has been through (Hamblin, 2010). A veteran will learn to cope with emotions such as shame, guilt, anger, rage, fear, and anxiety. Sharing with the group can also help a veteran build self-confidence and trust (Hamblin, 2010). A veteran then has the opportunity to focus on the present life, rather than feeling overwhelmed by the past, and is doing so with the support of his or her peers.

Family therapy is also an important component to any therapy, since PTSD affects the whole family. A veteran's partner and/or children may not understand why his or her family member with PTSD experiences symptoms. A therapist will help the veteran with PTSD and his or her family learn to cope with the symptoms of the disorder. According to Johnson (2000), psycho-educational groups teach coping strategies and educate veterans and their partners about the effects of trauma on individuals and families. Often these groups function as self-help groups for partners of veterans. Johnson (2000) asserts that the first steps for partners of veterans with PTSD include gaining a better understanding of PTSD, and the impact on families by gathering information (2006). Effective treatment should involve family psycho-education, support groups for partners, children, and veterans, concurrent individual treatment, and couple therapy (Johnson, 2000). Ruscio, Weathers, King, and Kling (2002) have found preliminary research which encourages group therapy and offers encouragement for the use of group treatment for female partners of veterans (2002). Several researchers have begun exploring the benefits of family or couples therapy for both the veteran and other family members (Johnson, 2000).

Common Problems in Relationships with Veterans Diagnosed with PTSD

Research by Calhoun, Beckham, and Bosworth, (2002) that has examined the effect of PTSD on intimate relationships reveals severe and pervasive negative effects on marital adjustment, general family functioning, and the mental health of partners and children (2002).

These negative effects, according to Calhoun, Beckham, and Bosworth (2002), result in such problems as compromised parenting, family violence, divorce, sexual problems, aggression and caregiver burden (2002). Additionally, according to Mikulincer, Florian, and Solomon (1995), male veterans with PTSD are more likely to report marital or relational problems, higher levels of parenting problems, and generally poorer family adjustment than veterans without PTSD (1995). Cosgrove, Gordon, Bernie, Hami, Montonya, and Stein (2002) state research has shown that veterans with PTSD are less self-disclosing and expressive with their partners than veterans without PTSD. Veterans with PTSD and their wives have reported a greater sense of anxiety around intimacy (Cosgrove, et al., 2002). Solomon, Waysman, Avitzur, and Enoch (1991) further support this finding, which is a result of impaired relationship functioning; a higher rate of separation and divorce exists in the veteran population with PTSD, compared to veterans without PTSD (1991).

According to Solomon et al., (1991), studies have found that, in addition to more general relationship problems, families of veterans with PTSD have more family violence, more physical and verbal aggression, and more instances of violence against a partner (1991). Solomon et al.'s research (1991) shows that female partners of veterans with PTSD also self-reported higher rates of perpetrating family violence than did the partners of veterans without PTSD (1991). PTSD can also affect the mental health and life satisfaction of a veteran's partner.

Numerous studies by Solomon, et al., (1991) have found that partners of veterans with PTSD or other combat stress reactions have a greater likelihood of developing their own mental health problems compared with partners of veterans without PTSD and combat related stress reactions. Nelson and Wright (1996) indicate that partners of PTSD-diagnosed veterans often describe difficulty coping with their partners' PTSD symptoms, including stress because their

needs are unmet, and experiences of physical and emotional violence (1996). Alternatively, the partners' mental health symptoms may be the result of their own experiences of trauma, related to living with a veteran with PTSD (e.g., increased risk of domestic violence) or related to a prior trauma (Nelson & Wright, 1996). The veteran with PTSD may not be functioning well within the family unit, which can place increased responsibilities on his or her partner.

According to Nelson and Wright (1996), caregiver burden is one construct used to categorize the types of difficulties associated with caring for someone with a chronic illness, such as PTSD. Caregiver burden includes the objective difficulties of this work (e.g., financial strain), as well as the subjective problems associated with caregiver demands (e.g., emotional strain). Nelson and Wright (1996) note that wives of veterans diagnosed with PTSD tend to assume greater responsibility for household tasks (e.g., finances, time management, house upkeep,) and the maintenance of relationships (e.g., children and extended family). Not only partners, but also children of veterans with PTSD also experience the negative impact of PTSD symptoms.

The Effects of a Veteran's PTSD on his or her Children

According to Sayers, Farrow, Ross, and Oslin (2009), children of veterans with PTSD can experience social and behavioral problems, emotional problems and secondary traumatization; such problems may continue into teenage years. Families of veterans with PTSD can experience more violence than those without PTSD, and which can cause violent behaviors in children. According to the authors, children of veterans with PTSD have more behavioral, school, and relationship problems (Sayers, et al., 2009). They are more aggressive and hyperactive than children of veterans who do not have PTSD.

With the aforementioned knowledge in mind, one can see the need for mental healthcare for not only the veterans with PTSD, but also their families. Treatment is readily available for the veteran and his or her family; however, stigma, real and perceived, can stand in the way of seeking mental health treatment.

Stigma and Mental Health Treatment

According to Burnam, Meridith, Tanielian, and Jaycox (2010) the Department of Defense (DoD) Task Force on Mental Health, there is a stigma of seeking mental health (and substance abuse) treatment; unfortunately the real and perceived possibility of stigma has kept many veterans from seeking much needed therapy. The DoD Task Force on Mental Health identified the stigma of mental illness as a significant issue preventing service members/combat veterans from seeking help for mental health problems and made recommendations to dispel stigma (Burnam et al., 2010). Social, cultural, and personal factors impede or facilitate service members' and veterans' access to mental health care (Burnam et al., 2010). When negative attitudes about those who experience mental health conditions or who receive mental health care are widely held by service members, as they pose a significant hurdle to effective mental health assessment and treatment (Burnam et al., 2010). When individuals do not seek the mental health treatment needed, the disorder can worsen to the point of a veteran having thoughts of suicide.

PTSD and Suicide

According to researchers (Burnam et al., 2010) working with Iraq and Afghanistan combat veterans found PTSD to be the current most common mental disorder among veterans returning from service from the middle east, is associated with increased risk for thoughts of suicide (Burnam et al., 2010) Results of the study indicated that veterans who screened positive for PTSD were four times more likely to report suicide related thoughts than veterans without the

disorder (Burnam et al., 2010). The research establishes the risk factor for thoughts of suicide of veterans with PTSD and two or more co-morbid mental disorders were significantly more likely to experience thoughts of suicide relative to veterans with PTSD alone (Burnam et al., 2010). As many as 46% of veterans in the study experienced suicidal thoughts or behaviors in the month prior to seeking care, and of those veterans, 3% reported an actual suicide attempt within four months prior to seeking care (Burnam et al., 2010). Suicide-related thoughts and behaviors discovered in a returning veteran who has been diagnosed with PTSD, especially in with two or more other co-morbid mental disorders, may suggest an increased risk for suicide (Burnam et al., 2010). Stigma is a barrier to seeking mental health treatment; this barrier can further increase risk of suicide.

CHAPTER 3

Discussion & Implications

Counseling Strategies and Treatment Protocol

Since PTSD is often co-morbid with Axis I and Axis II disorders, concurrent treatment of co-morbid disorders is paramount for optimal rehabilitation (Souza & Spates, 2008). Having both PTSD and a drinking problem can make both problems worse. For this reason, alcohol use problems must be treated in conjunction with PTSD. Unfortunately, these issues are both addressed separately if they are addressed at all. Alcohol use can affect sleep, cause anger, and irritability, anxiety, depression, and work or relationship problems (Souza & Spates, 2008). Counseling strategies help reduce these symptoms. There are specific treatment methods for PTSD and substance use conditions (Souza & Spates, 2008). Individuals with PTSD and substance abuse demonstrate markedly less improvement during treatment in several areas than substance abuse alone (Souza & Spates, 2008). “These include the acquisition of more adaptive coping skills, belief in positive conditions regarding their abilities, and general ability to manage psychological distress” (Souza & Spates, 2008 p.13). With this in mind, counseling strategies for PTSD have multiple approaches to therapy. For example, an individual is in treatment for PTSD symptoms and in addition to individual therapy for PTSD, the individual attends group and possible family counseling. If there is a substance use disorder, it may be treated during different counseling sessions or within the same counseling session, and the veteran may attend group counseling for a substance abuse disorder. Treatment will always need to be individualized to best suit the veteran’s specific treatment needs. Since PTSD affects the entire family, it is

important for partners and children of veterans with PTSD to seek individual and group counseling.

Increasing Need for Services and Making Them Available

According to Seal, Maguen, Cohen, Gima, Metzler, Ren, Bertenthal, and Maramar (2010) large scale studies of Operation Enduring Freedom (OEF) and Operation Iraq Freedom (OIF) veterans in VA health care, the authors reported on the growing burden of mental health disorders, including trends and risk factors for mental health diagnosis in new users of VA health care (2010). The authors found that, “Between April 2002 and March 2008, data was reported on 289,328 Iraq and Afghanistan veterans using VA health care for the first time; 36.9% received one or more mental health diagnosis; 21.8% received a diagnosis of PTSD; 17.4% a diagnosis of depression; 7% for alcohol use disorder; and 3% for substance use disorder” (Seal, et, al., 2010 p. 6). They state, “Adjusted 2-year prevalence rates of PTSD increased 4-7 times after the invasion of Iraq. Active duty veterans under the age of 25 had the highest rates of PTSD and alcohol and drug use disorder diagnosis compared to active-duty veterans greater than age 40” (Seal, et, al., 2010p. 7). Strategies are needed to encourage younger vets to seek treatment and continue with the course of treatment.

In a study by Seal, et al., (2010) many veterans are not getting enough treatment for PTSD. Although the Department of Veteran Affairs is working to begin and implement treatments nationwide as fast as possible to adequately provide for newly diagnosed PTSD patients, there are still significant barriers to veterans getting a full course of PTSD treatment (Seal, et al., 2010). The study also cites more than 230,000 Iraq and Afghanistan war veterans who sought treatment for the first time at VA health care facilities nationwide between 2002 and 2008 (Seal, et al., 2010). According to the study, more than 20 percent of these veterans, almost

50,000, received a new PTSD diagnosis (Seal, et al., 2010). Treatments that have been shown to be effective for PTSD typically require 10-12 weekly sessions. While the VA follows these recommendations, however, fewer than 10 percent of those Iraq and Afghanistan veterans with newly diagnosed PTSD complete the recommended course/amount of PTSD treatment (Seal, et al., 2010). The study also states that when the timespan was expanded to a year rather than four months, fewer than 30 percent of the veterans completed the recommended course of treatment (Seal, et al., 2010).

The study by Seal, et al., (2010) showed that there are groups of veterans who are less likely to receive adequate care than others, such as male veterans (compared to female veterans), veterans under twenty-five years old, veterans who received their PTSD diagnosis from primary care clinics (requiring referral to a mental health program), and veterans living in rural areas (Seal, et al., 2010). Dr. Karen Seal, head researcher for the study and practitioner at the San Francisco Veteran Affairs Medical Center, states that while the majority of veterans with PTSD attend at least one mental health follow-up visit, there are still substantial barriers to care that prevent the majority from completing what is considered an adequate course of PTSD treatment (Seal, et al., 2010). Many of the obstacles are "system-level or are personal barriers resulting in lack of patient follow-up on appointments, busy lives, child care, financial pressures, and concern about the adverse impact of being labeled with PTSD on their military or civilian careers, and perceptions of being weak and shame of mental illness/stigma." (Seal, et al., p.7 2010). This shows that there is further need for the VA and other healthcare systems to develop new and innovative ways to overcome barriers to care in delivering these effective mental health treatments.

What Providers Have Learned from Research

Department of Defense and the VA have adopted a number of innovative strategies to overcome the obstacles to care for returning combat veterans from Iraq and Afghanistan. Integrated, co-related care where mental health services are provided inside primary care is one approach, with a well-established evidence-base for the successful treatment of depression in co-related mental health primary-care clinics (Burnam, Meridith, Tanielian, & Jaycox, 2010). Efforts are being made to de-stigmatize mental health services by reframing them as stress management training for combat stress reactions, rather than psychiatric treatment for mental disorders. In an effort to address geographic barriers to care and stigma, efforts are being made to bring care to veterans utilizing the Internet and telephone care as an alternative to traditional clinic visits (Burnam et al., 2010). Motivational interviewing techniques are used to address the stigma concerns. By employing these updated strategies the hope is to reduce the risk of delayed treatment seeking, which will result in higher rates of co-occurring depression, alcohol and drug use, interpersonal violence, physical health problems, and occupational disability (Burnam et al., 2010).

Research helps to improve veteran's lives by working to overcome problems like PTSD. Research allows one to: understand the problem and its effects, develop and test treatments to reduce and treat the problem, and find ways to prevent the problem in the first place. The V.A is trying to develop new and better ways to treat and prevent PTSD. Research at the National Center for PTSD includes many ongoing studies about PTSD. Studies include: Survey of Experiences of Returning Veterans (SERV), Telemental Health and Cognitive Processing Therapy for Rural Combat Veterans with PTSD (Burnam et al., 2010).

Role of Rehabilitation Counselor

The role of the rehabilitation counselor is to have the skills and knowledge to recognize and implement effective treatment protocol as well as to be knowledgeable of the available resources for the veteran with PTSD and resources available for the veteran's family.

Rehabilitation counselors also need to recognize any possible barriers that may prevent a veteran from completing treatment. Since treatment of individuals with PTSD relies on a multidimensional approach, treatment options include patient education, social support, and anxiety management through psychotherapy and pharmacologic intervention. A rehabilitation counselor should be able to identify possible services a veteran may need, and make appropriate referrals for such services.

Implementing effective treatment for PTSD includes gaining a better understanding of PTSD, and the impact it has on families. Effective treatment should involve family psycho-education, support groups for both partners, children, and the individual, concurrent individual treatment, and couple or family therapy. Rehabilitation counselors should also recommend psycho-educational groups because they teach coping strategies and educate veterans and their partners about the effects of trauma on individuals and families. Psycho-educational groups can function as support groups for partners of veterans with PTSD. Individual therapy for both the veteran and his or her partner is also an important treatment component. Couples or family therapy may also be highly effective treatment for individuals' symptoms and problems within the family system. With this in mind, the rehabilitation counselor must demonstrate the need for not only the veteran to receive treatment, but for the veteran's family to seek appropriate treatment as well. The treatment options listed above are but a few of the available approaches that a rehabilitation counselor can utilize to encourage partners of veterans with

PTSD and other co-occurring disorders in seeking improved family relationships and mental health.

It is important for a rehabilitation counselor to recognize the effects co-occurring disorders have on the family. Also, it is important to understand how stigma has hampered some veterans from seeking mental health care, and what has been done to change the negative perception towards receiving mental health care. The rehabilitation counselors can provide information to the community about the effects of stigma and ways that it is being combated.

The role of the rehabilitation counselor is to have thorough knowledge of the various combinations of individual therapy that are utilized to treat individuals with PTSD; this is not only important in providing treatment, but also to make an appropriate referral. Each individual has a different experience and specific treatment(s) are individualized to meet the client's needs. Since co-occurring disorders are common with PTSD, an individual would be in treatment for each specific disorder concurrently for optimal rehabilitative outcome.

Future Directions in PTSD Research and Care

According to Burnam, Meridith, Tanielian, and Jaycox (2010) The VA is testing a new data collection tool, the Brief Addiction Monitor, that could be used to monitor treatment effectiveness at the individual patient and VA medical center levels. In a recent survey by the RAND Corporation, of nearly 2,000 veterans of operations Enduring Freedom and Iraqi Freedom, half the respondents reported they had a friend who was killed or seriously wounded (Burnam et al., 2010). Nearly 45 percent said they saw dead or seriously injured non-combatants. The rate of respondents who met the diagnostic criteria for PTSD or depression was relatively high, at 18.5 percent (Burnam et al., 2010). Based on these data, RAND estimated that some

300,000 veterans who have returned from Iraq and Afghanistan are suffering from PTSD or major depression (Burnam et al., 2010).

Approaches to combating stigma, Public Education Campaigns; the DoD task force on Mental Health asserted that an anti-stigma public-education campaign could use evidence-based techniques to effectively spreadfactual information about mental health conditions (Burnam et al., 2010). Efforts to convey the effectiveness of treatment should further motivate individuals to seek treatment and to complete treatment.

Conclusion

It is important for veterans, their families and rehabilitation counselors to recognize the psychosocial effects of PTSD. Being knowledgeable of co-occurring disorders and negative coping, and how they impact the life of the veteran with PTSD and their families, is paramount in the rehabilitative process.

The stigma of mental illness, real and perceived, can prevent a veteran from seeking and utilizing mental health treatment needed in order to gain optimal rehabilitative recovery. The DoD has created campaigns currently being put in place to reduce stigma and encourage those who need treatment for mental illness and/or co-morbid disorders to seek them. Rehabilitation counselors must be familiar with the criteria (DSM IV-TR) to meet requirements of PTSD diagnosis, as well as the types of effective treatments for PTSD and co-occurring disorders. The VA provides resources and information about how such resources that can best help the veteran with PTSD and co-occurring disorders, as well as their families, work toward treatment goals.

More veterans returning from Iraq and Afghanistan are in need of mental health treatment for PTSD. In anticipation of this influx, the VA must work to expand services and resources while simultaneously reducing barriers for veterans seeking mental health treatment.

Rehabilitation counselors need to be aware of the above issues in order to effectively provide services and appropriate referrals to returning veterans. While there are many effective treatment options for the veteran with PTSD and his or her family members, there is still a need for further research.

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Research Paper Title:
 Psychosocial Issues of Post-Traumatic Stress Disorder and Treatment.

Major Professor: Dr. James Bordieri, Ph.D